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SOCIAL ASPECTS OF HOMOSEXUALITY*

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Social anthropologists have found that homosexuals and homosexual acts have occurred in all civilizations without exception. The reaction to homosexuality has varied from severe condemnation (as in our own society), through indifference, to acceptance, and in a few cases, even to glorification, where the high priests of a religious cult have been exclusively homosexual. No matter what the reactions have been, no civilization has succeeded in stamping it out (Westwood, 1952).

In Great Britain homosexual behaviour has been recorded in every century and under every régime. It has appeared in every generation and in every class of society. It is to be found in every section of the community to-day, from those possessing a high degree of intelligence to the "dullest oafs", as the Wolfenden Report (1957) puts it. This is often accepted intellectually, yet people are often surprised by its implications. It means, of course, that some criminals are homosexual, and so are some policemen; some patients are homosexual, and so are some doctors; some spies are homosexual, and so are some politicians.

Very little is known about the causes of homosexuality, and only a little progress has been made in its treatment. Broadly speaking there are four ways of treating the homosexual condition. First there is the administration of oestrogens. This can reduce the strength of the sex drive, but it has been found that it has no effect whatever on the direction of the sex drive, and will not turn a homosexual into a heterosexual. It will merely help a man to keep his homosexual desires under control. A similar form of treatment is castration, which has been used in Denmark and Norway (Bremer, 1959). The effects are the same as for oestrogen treatment—it reduces the sexual activity but the fundamental sexual direction remains unchanged. A third form of treatment is aversion therapy for which startling success has recently been claimed (James, 1962), but very little work has been done on homosexuality so far, and the success rate of aversion therapy cannot be judged until a careful long-term study of the results has been carried out.

The fourth and most usual way of treating homosexuals is by some form of psychotherapy. It is extremely difficult to find out how successful this is. Our only sources of information are the records kept by individual psychiatrists, and inferences drawn from these records are hazardous at best. Furthermore, psychotherapy is essentially an intellectual process. This means that there are certain minimum requirements before the treatment can work. There is a minimum level of intelligence and there must also be a certain degree of motivation—the patient has got to be interested in the treatment, and at least think some kind of cure is possible.

If a man goes to a psychiatrist two or three times and then defaults, the psychiatrist can legitimately claim that this is not a failure of treatment, because the treatment had hardly started. But in attempting to judge the total success rate of psychiatric treatment, we should have to include not only those who gave up treatment, but also those who would not co-operate with a psychiatrist even if you paid them.

All we can say at present is that the little evidence available shows that psychiatric treatment has a low success rate and we do not know if it is more effective than the available alternatives.

Of course another alternative is to do nothing; for some men go through a period of homosexual behaviour and then just give it up without receiving treatment of any kind.

Even if the success rate of psychiatric treatment has been underestimated, there are certainly not enough psychiatrists to treat the many thousands of homosexuals, and they have more urgent and more important cases to treat. Medical research into the

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causes of homosexuality should not be discouraged and we should do everything possible to provide some kind of help for the distressed homosexual, but as far as we can tell there is going to be very little difference in the total amount of homosexuality in the next decade or so.

All the new refined sociological techniques are useless when one attempts to measure the size of this problem, for the reason that many homosexuals will go to enormous lengths to cover up their homosexual interests. There is no reason to suppose that the number of homosexuals has increased, but it is possible that the number of homosexual acts has increased. As our attitude towards sexual activities becomes more permissive, it is possible that some homosexuals are finding it easier to find sexual partners, and it is also possible that some men who are normally heterosexual will occasionally take part in an isolated homosexual adventure.

This is the part of the problem that worries many people, some of whom seem to regard homosexuality as a kind of infectious disease. It is true that some homosexuals try to persuade normal men to have homosexual relations with them. While these men form a sizeable minority, it is certainly not true that the majority of homosexuals act in this way. Westwood (1960) found that 18 per cent. of his sample were interested in non-homosexuals as partners.

The explanation for this is not as sinister as some people seem to think. Putting it quite simply, a homosexual is sexually attracted to men, not women, not imitation women and not effeminate poufs. When the subjects were asked to describe their ideal sexual partner, nearly all of them emphasized physical attributes that were essentially masculine. It is therefore not surprising that some homosexuals will try to tempt other men.

But those homosexuals who are interested in non-homosexuals as partners can only become a serious menace if we assume that a normal man can become homosexual by contagion. This is the assumption that is accepted without question by many politicians. The phrase they most often use is that homosexuality is a "cancer" in our society. But this analogy seriously distorts the picture. It conjures up an image of society as an essentially healthy organism invaded by alien substances. The policeman is seen as a kind of doctor whose job it is to remove the cancer without altering the character of the organism itself. But the problem cannot be dealt with in isolation. It is a social problem and concerns the whole of the social setting.

All the pressures of our society are geared towards idealizing heterosexual love. All propaganda, from art to advertising, extols the beauty and pleasure of heterosexual relations. In the face of these extremely powerful social pressures, the homosexual certainly has a tough job when he sets out to make a convert. And there is no evidence to show that one man can turn another into a homosexual by persuading him to take part in a homosexual act. In 49 out of the 76 societies studied by Ford and Beach (1952), homosexuality was regarded with tolerance, but in no society was it ever the dominant mode of sexual behaviour.

Nor does it seem possible that seduction can lead to an increase in the number of homosexuals. Two separate researchers, one in America (Doshay, 1943) and the other in Holland (Tolsma, 1957), have found that there is no connexion between seduction as a child and the later development of homosexual tendencies. It has been pointed out that widespread homosexuality in boarding schools is really the result of curiosity and experimentation in the somewhat unnatural all-male environment, and does not appear to have a lasting effect (Heron, 1963).

Everyone has heard of cases in which adult men have been found guilty of interfering with small children. In fact, popular opinion seems to assume that all homosexuals are attracted to young boys. This may be because child molesters are more likely to get into trouble with the police and newspapers more often report these cases.

But men who find other adult men sexually attractive are unlikely to be interested in a boy of sixteen or younger. Child molesters and homosexuals have very little in common; indeed in many respects the child molesters correlate more closely with heterosexuals than with homosexuals. And it is not uncommon to find that men who feel the urge to interfere with small boys are also attracted to small girls. It is beyond dispute that child molesting is a different phenomenon and is rarer than homosexuality (Curran and Parr, 1957).

An increase in the number of homosexuals attending special treatment centres does not necessarily mean an increase in the total incidence of homosexuality. The figures from a venereal diseases clinic are the records of the activities of that clinic, and in this sense they are like the book-keeping in a commercial organization—the records of "business transacted". They describe the behaviour of the people working in the clinic, rather than the behaviour of the patients with venereal disease. Figures from a particular clinic may not represent a trend throughout the country. And this is especially so as regards this problem, because there is no doubt that particular doctors and particular clinics get a good or bad reputation in homosexual coteries. When a homo-

sexual discovers that he has a venereal infection, he goes to his homosexual friends who recommend a particular clinic.

A rise in the figure may be a reason for congratulation in one way. People are certainly more aware of this problem, and it may be that homosexuals are less afraid of attending clinics and more prepared to admit that they are homosexual when they get there. Eight years ago Jefferiss (1956) found a much lower proportion of non-gonococcal urethritis among homosexuals and he wondered if this meant that homosexuals do not risk coming to a clinic unless forced to do so by acute illness.

In a report by the BMA and British Cooperative Clinical Group (1959), it was suggested that, if all the cases treated outside the hospital service in 1956 were added to those returned by the special treatment clinics, there would be a rise of one-quarter in the figures for syphilis and a rise of one-seventh in those for gonorrhoea and non-gonococcal urethritis. It is not hard to believe that homosexuals are finding it easier to visit clinics to-day than 8 years ago. Before the publication of the Wolfenden Report the subject of homosexuality was discussed only rarely by doctors and hardly at all by laymen. If more homosexuals are now prepared to come to the clinics instead of going to physicians in private practice, this is an improvement from the medical aspect because the venereologist has more experience and better laboratory facilities; there is also a social advantage, because it is unlikely that the general practitioner will be able to spend much time tracing contacts.

It cannot be assumed, however, that the clinics are seeing all the homosexuals who are infected. There are still some men who are under the impression that it is not possible for a homosexual to contract venereal infections. Here are two quotations from homosexuals interviewed within the last year:

"I attended a lecture on V.D. in the R.A.F., but I didn't think it applied to me because I didn't go with women."

This man was having frequent homosexual experiences at that time. Another man answered the question about venereal diseases by saying:

"You'd never get V.D. from a homosexual, or if you did, it would be because he was bisexual and had been with a woman. A homosexual tends to take more care and keep himself clean. Some normals never have a bath from one month to the next."

It is worth trying to see how far a homosexual is at risk as regards venereal diseases. First of all we should note that not all homosexuals are promiscous. In Westwood's group of 127 homosexuals, 32 per cent. lived with another man in a situation somewhat akin to a happy marriage; about a third (35 per cent.) had had a series of affairs which lasted over a year but which eventually broke up; only the remaining 33 per cent. were promiscuous.

The actual frequency of homosexual acts depends upon opportunity. Those who have regular partners tend to have higher frequencies than those who are for ever seeking new partners. As Gibbens and Silberman (1960) have noted, the promiscuous work very hard for infrequent rewards.

Many people divide homosexuals into active and passive. In making this division, it is not always clear whether they refer to the sexual techniques adopted, or whether they describe personality traits. Furthermore, it is not always clear what is meant—particularly when oral-genital techniques are being considered. Bieber (1962) and associates use the words "insertor" and "insertee" which are less likely to be misunderstood. The insertor intromits his penis into an orifice. The insertee accepts the penis into his orifice. It has been found that homosexuals who have a preference for being the insertee in oral-genital relations tend to have the same preference in anal intercourse. It does not follow, however, that bisexuals always prefer to be the insertor in anal intercourse. A dichotomic classification into insertor and insertee, or active and passive, is not useful and does not describe all cases. The same person may be active with one person, passive with another, and both active and passive with a third. Furthermore Chesser (1958), Bergler (1957), Glover (1957), and other workers have noted that a large proportion of homosexuals do not like anal intercourse.

Although it is possible to catch venereal disease from mutual masturbation or from what Kinsey calls "genital apposition", obviously the risk is much less than in anal intercourse. It is clear, therefore, that there are some homosexuals who do not run much risk of infection, partly because they do not often change partners, and partly because they practise sexual techniques other than anal intercourse.

Although there are a surprising number of homosexuals who settle down and live in pairs in something approaching domestic harmony, one will have to accept, if one is going to be realistic about homosexuals, that a large number of them are exceedingly promiscuous. As long as we continue to treat them like criminals, this situation is not going to alter. It must not be forgotten that every time a homosexual obtains sexual satisfaction, he becomes a criminal. And this has a profound effect on him.

It is sometimes a long painful process before a homosexual learns to accept himself and adjust to his deviation so that he can live at peace with himself, but he will make this adjustment sooner or later. During the course of this adjustment he is forced to examine the moral values that the rest of us accept without question. Thus, by the time he has come to accept his homosexual condition, he will probably have adopted a fairly unorthodox view on other matters. So it comes about that the association of sexual intercourse with romantic love is not important to many homosexuals. Instead they regard sexual relations only as a highly pleasurable physical activity. Viewed in this light, fidelity is unimportant and promiscuity is inevitable. And where there is promiscuity, there is the probability of a high rate of venereal disease. It should also be remembered that the promiscuous homosexual does not use a sheath, and that this increases the chance of contracting and passing on an infection.

Obviously it is very important that the infected homosexual should go promptly and without fear to a clinic. But it is not always easy for him to do this. As MacDonald (1949) has pointed out, "It is unreasonable to expect a patient not to feel some diffidence in admitting to an act rendering him liable to a police prosecution." Here is part of the editorial of the October, 1962, edition of *ONE*, an American periodical with quite a large circulation among homosexuals in the U.S.A.

"It is yet to be established that information given to the public health office is not also available to the public, the police, and the courts. . . . As it now stands the homosexual may be afraid of having venereal disease, but he may also be afraid of having a check-up. As long as the law against homosexual acts exists this is not illogical. But the solution is simple. Under no conditions, or for any reasons, should a homosexual set one foot inside a public health office. If anyone of us needs a doctor, let him go straight to a private physician. . . ."

It is unlikely that many homosexuals in Great Britain would take such an extreme view, but the danger of misunderstanding is ever present, for it takes only the merest suspicion of mistrust, no matter how unjustified, and the rumour will spread around every homosexual club in London. It is clear that the existing law puts the homosexual, and in a sense, the venereologist, in an awkward position. This is why the venereologist cannot stand apart from the controversy about homosexual law reform.

Sometimes there appears to be some justification for a homosexual's reluctance to go to a clinic. Here are just four quotations from homosexuals interviewed recently:

"The first time I got V.D. I went to the X. . . hospital. I had it in the back and there was no disguising how I got it. If I'd stamped on a baby I couldn't have been given darker looks. So next time I went to Y. . .'s hospital where they were very good. They said: 'We're not interested in your morals, we're here to cure you'."

"Dr Z. . . . is very good to me. The orderlies were a bit derisive at first, but now they've got to know me as I often go in for a check-up."

"I told them I was homosexual because I felt I ought to have a thorough medical examination. Only one orderly was unpleasant; he sneered when he saw the sign on my card."

"It's ghastly in that clinic. One is treated like a criminal. The doctor is off-hand and unpleasant. If that's the job the man has chosen to do, he should make more effort to do it decently."

These slights may be more imaginary than real. Bergler (1957) has said that all homosexuals are "injustice collectors", and it is probably true that a homosexual in a clinic will easily take offence. The trouble is that, whether the slight is real or imagined, the result is likely to be that the patient will not return for further treatment and will probably discourage his friends from attending. Not all the homosexuals complained. Most of them felt they were treated quite well. One man said:

"The doctor was very nice and one of the orderlies made a pass at me."

It is worth noting that the young inexperienced homosexual does not know where to find sexual partners and that he is more likely to agree to have homosexual relations with a man he has picked up in a public lavatory. Quite often the ones who have the most sordid episodes are the least experienced. The man who knows his way around the London homosexual merry-go-round is better able to look after himself.

People who live in large cities will have no difficulty in finding a clinic where they are not known socially by any of the staff. But in small communities a visit to the local clinic may cause more embarrassment because there is a chance that the patient may be known to the doctor or others working there. The British Cooperative Clinical Group (1962) found that there were very few homosexuals in small towns and rural clinics. There may be more than one reason for this.

Nearly all homosexuals are fearful of social disapproval and legal punishment, and inevitably this complicates the control problem. If he is bisexual he will be inclined to conceal his homosexual experiences and talk frankly about his heterosexual partners. The homosexual with a penile infection will sometimes make up the names of non-existent women partners to direct attention away from his homosexuality.

Then there may be other men who dare not reveal anything about themselves even to their homosexual partners. These homosexual activities are so anonymous that no addresses or telephone numbers are exchanged. This may happen even when two men have been meeting regularly for a long time and yet are known to each other only by their first names. Such men will be quite genuinely unable to give much information about the source of their infection.

Others spend all their leisure time in groups that are exclusively homosexual. Perhaps the best way to get their co-operation is to appeal to the group solidarity which is quite strong among homosexuals as it is among any minority group: all homosexuals will get a bad reputation if it became known that there is a high rate of V.D. among them. If the homosexual patient does not have these altruistic group feelings, it may be possible to appeal to his self-interest by suggesting that his circle is so small that he will probably catch V.D. again if he does not help to cut down the risk of infection.

The fact that homosexual groups are relatively small may give some encouragement to venereologists. Bradshaw (1961) described how he cracked down on an epidemic of syphilis among homosexuals in Texas with a ruthlessness that will probably surprise some people here. One man was interviewed for 2½ hours and he gave the names of 28 contacts. In all, 135 contacts were named, 36 of whom had infections. Three of the 36 infected individuals had been treated previously for infectious syphilis, and all three of these homosexual contacts had previously named only heterosexual partners. Bradshaw felt that speed was essential and he even telephoned the names and addresses of out-of-town contacts to Health Departments in other States. He also arranged for the patients of private physicians to be treated at the clinic without identification. He also used what he called "cluster interviews"—by which he tried to persuade the infected patients to send along their associates as well as their actual sex partners.

Although there have been some remarkable successes in tracing the source of infection among homosexuals in Great Britain, there is a case for closer co-operation between all the clinics, perhaps through the Medical Officers of Health, as suggested by Burgess (1963). An attempt should be made to measure the success rate of contact tracing.

We need to know more about the homosexual who becomes infected, and more about the real extent of the problem. Jefferiss (1962) reported that 70 per cent. of the male patients with early syphilis attending a London clinic admitted homosexual contacts. Laird (1962) has suggested that homosexuality accounts for the country-wide increase in early syphilis. It should be possible to provide information on the number of patients with ano-rectal gonorrhoea and syphilis, and also on the number with penile infections who admit to homosexual contacts.

Summary

Treatments for turning homosexuals into heterosexuals have a low success rate. Consequently the number of homosexuals in Great Britain is not likely to decrease in the foreseeable future.

An increase in the number of homosexual acts does not mean that there will be an increase in the number of homosexuals. Homosexuality is not contagious and the effects of seduction have been exaggerated.

Homosexuals are now more likely to admit their sexual inclinations than in the past, and are more likely to go to a clinic for treatment.

Not all homosexuals are promiscuous and not all of them prefer anal intercourse; therefore some of them are not at risk.

Practising homosexuals are lawbreakers and often fearful of being discovered. They distrust the authorities and easily take offence. Many of them will not co-operate in tracing the source of infection and some will intentionally mislead. This is not necessarily due to a flaw in the homosexual personality, but is caused by the legal and social setting in which the homosexual finds himself. Some lead lonely lives and never learn the names of their partners. Those who mix in homosexual groups will tend to be more promiscuous and the infection can sometimes spread with the speed of an epidemic.

By its very nature this problem will not disappear overnight, but the incidence of venereal disease among homosexuals can be reduced by obtaining more information about homosexuals from the clinics, giving more information about venereal diseases to homosexuals, and developing a more enlightened legal and social attitude to the problem.

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Considérations sociales de l'homosexualité

RÉSUMÉ

Les efforts de ceux qui veulent rendre hétérosexuels les homosexuels ont eu peu de succès. Par conséquent on ne s'attend pas à ce que leur nombre diminue d'ici peu au Royaume-Uni.

Une augmentation du nombre des actes homosexuels n'indique pas nécessairement une augmentation du nombre des individus homosexuels. Cette déviation n'est pas contagieuse et l'effet de la séduction des jeunes gens a été exagérée. Les gens atteints avouent plus franchement leurs inclinations et vont plus ouvertement aux cliniques qu'auparavant.

Les homosexuels ne mènent pas tous une vie irrégulière; ils ne pratiquent pas tous la sodomie et ne sont pas tous en danger d'infection.

Parce qu'ils sont hors-la-loi et ont peur de scandale et de découverte, ils se méfient des autorités et s'offensent de toute censure. Plusieurs ne veulent pas aider au dépistage des contacts et donnent même de faux renseignments. Ceci n'est pas une faute particulière des homosexuels, mais provient des circonstances légales et sociales de notre civilisation.

Il y en a des infortunés qui vivent en solitude et ne connaissent même pas les noms de leurs contacts sexuels. Ceux qui vivent dans un milieu homosexuel sont plus libres dans leurs rapports et parmi un tel groupe une infection peut se propager comme une épidémie.

Ce problème de l'homosexualité ne disparaîtra pas tout d'un coup, mais le nombre atteint de maladies vénériennes peut être réduit par les mesures suivants.

— obtenir des cliniques plus de renseignments sur les homosexuels

— renseigner les homosexuels au sujet du péril vénérien

— adopter une attitude plus humaine vers les homosexuels.